DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE

2007 COMMUNITY ALTERNATIVE PROGRAM FOR PERSONS WITH MENTAL RETARDATION/DEVELOPMENTAL DISABILITIES (CAP-MR/DD) COST REPORT EXEMPTION FORM

Cost Report Due Date: SEPTEMBER 30, 2007

PLEASE COMPLETE AND SUBMIT IF EXEMPT

This completed form MUST be submitted in order to request exemption.

Federal Tax ID:_____ ***REQUIRED**

Corporate Name: _____

Address: _____

Phone Number: _____ Fax Number: _____

NPI and related Medicaid Provider Numbers: _____ _____

_____ _____ _____

_____ _____ _____

Please attach additional sheets if more space is needed for NPI and related Medicaid Provider #s.

We are requesting exemption from the 2007 Community Alternative Program for Persons with Mental Retardation/Developmental Disabilities (CAP-MR/DD) due to: [Indicate appropriate reason/s]

_____ was not in business for **at least 6 months** in the reporting period.

_____ does not meet the Medicaid minimum dollar threshold of **$500,000** per Agency **Federal Tax ID#** in revenue generated from providing CAP-MR/DD Services for the time period of July 1, 2006 through June 30, 2007. This threshold has been established based on cumulative revenue by Tax ID. For multi-facility agencies, combine the revenue for all individual facilities to determine if you meet the minimum dollar threshold.

_____ _____
(Date) (Signature of the Provider Agency)

_____
(Printed name of person signing above)

Return completed form via email, fax, or mail to:
N.C. Division of Medical Assistance
Financial Operations
2501 Mail Service Center
Raleigh, NC 27699-2501
Attention: Mishawn Davis
Fax: (919)715-2209
Email: mishawn.davis@ncmail.net